A Detailed Look at Meaningful Use

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IHS Office of Information Technology

Overview

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- Overview of EHR Certification and Meaningful Use
- Overview of CMS Incentive Programs
- Details of CMS Incentive Programs
- Stage I Meaningful Use Standards and Measures (for 2011-12)
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Disclaimer

PLEASE NOTE

- Information about incentives and measures is preliminary, based on CMS proposed rule dated 1/13/2010

- Final rule is expected in May–June 2010

Glossary

ARRA	American Recovery and Reinvestment Act of 2009
CAH	Critical Access Hospital
CCN	CMS Certification Number
CDA	Clinical Data Architecture
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare and Medicaid Services
EHR	Electronic Health Record
FFS	Fee-For-Service
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIO	Health Information Organization
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area

Glossary (Continued)

I/T/U	IHS Direct, Tribal, and Urban
IPC	Improving Patient Care
MAC	Medicare Administrative Contractor
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NQF	National Quality Forum
OIT	IHS Office of Information Technology
ONC	Office of the National Coordinator for Health Information Technology
POS	Place of Service
PQRI	Physician Quality Reporting Initiative
RHC	Rural Health Clinic
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
RPMS	Resource and Patient Management System
TIN	Taxpayer Identification Number

Real Life Example of Meaningful Use

Pumpkin

Meaningful Use of a Pumpkin

ARRA Funding and Its Impact on IHS

ARRA and HITECH

- As stated on www.recovery.gov website:
  - ARRA is an unprecedented effort to jumpstart our economy, create or save millions of jobs, and put a down payment on addressing long-neglected challenges so our country can thrive in the 21st century… **preserve and improve affordable health care**…"
  - Included in ARRA is the HITECH Act, which:
    - "Seeks to improve American health care delivery and patient care through an **unprecedented investment in health information technology**."

ARRA and HITECH (Continued)

- The HITECH Act Programs
  - **EHR Incentive Program:** Authorizes CMS to make incentive payments to eligible providers and hospitals to promote the *adoption and meaningful use* of interoperable certified EHR technology
  - **Health Information Technology Extension Program**: Establishes a national Health Information Technology Research Center and (HITRC) and Regional Extension Centers (RECs) to assist providers seeking to adopt and become meaningful users of certified EHRs

ARRA and HITECH (Continued)

- The HITECH Act Programs (Continued)
  - **State Health Information Exchange Cooperative Agreement Program:** Supports states or State Designated Entities (SDEs) in establishing health information exchange capability among providers and hospitals
  - **Other Programs:** Other programs are included to increase the health information technology workforce through expanded training opportunities

ARRA and HITECH (Continued)

- IHS received $85 million in ARRA funding for health information technology.
  - The IHS OIT has focused this funding to upgrade and extend electronic health information technology throughout Indian Country and to achieve meaningful use of the IHS RPMS EHR.

ARRA Objectives for IHS
Office of Information Technology

- Hire and deploy IT staff
- Upgrade the RPMS EHR so that it meets the requirements of meaningful use and achieves certification
- Deploy the certified RPMS EHR
- Implement a personal health record tool
- Upgrade the reliability, redundancy, and security of the IHS network
- Ensure an adequate telemedicine infrastructure

Overview of EHR Certification and Meaningful Use

Congressional Requirements for Meaningful Use

1. Use a *certified* EHR in a *meaningful* way.

2. Use an EHR that can *exchange information* with other systems electronically.

3. Submit reports to CMS that include *performance measures* proving meaningful use.

These requirements were published for public comment – *the comment period closed March 15, 2010.*

Meaningful Use Goals
and What They Mean to You

- Improve quality, safety, and efficiency, and reduce disparities
  - *Use computerized provider order entry*
- Engage patients and families in their healthcare
  - *Provide patients with electronic copy of their health information*
- Improve care coordination
  - *Exchange key clinical information with other providers*
- Improve population and public health
  - *Submit electronic data to immunization registries*
- Ensure adequate privacy and security protections for personal health information
  - *Protect electronic health information created or maintained in the EHR*
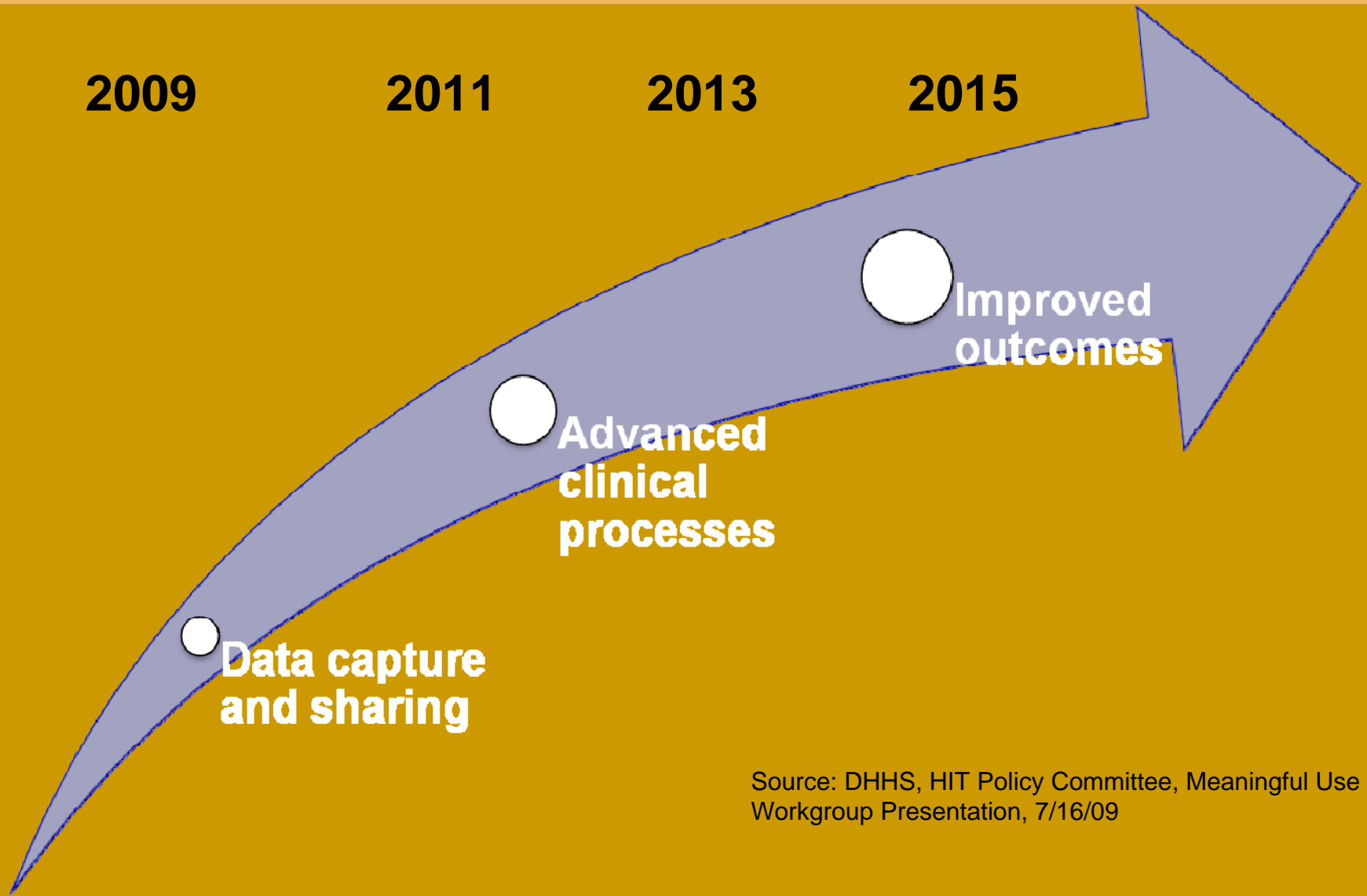
Meaningful Use Timeline

- Meaningful Use occurs in three stages, with Stage 1 starting in 2011
  - New rules will be published in 2013 and 2015 (Stages 2 and 3)–each stage will be more comprehensive
- Focus areas for each stage
  - Stage 1: Data capture and sharing
  - Stage 2: Advanced clinical processes*
  - Stage 3: Improved outcomes*

* Requirements for Stages 2 and 3 will be defined in future CMS rulemaking.

Bending the Curve

2009   2011   2013   2015

Data capture and sharing

Advanced clinical processes

Improved outcomes

Meaningful Use Timeline (Continued)

- The later you start, the more requirements you have to meet in a shorter period of time

Stage of Meaningful Use Criteria by Payment Year					
1st Payment Year	Payment Year				
	2011	2012	2013	2014	2015+
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015					Stage 3

NOTE: The number of payment years available and the last payment year that can be the first payment year for a provider or hospital varies between the EHR incentive programs.

EHR Certification and Relationship to Meaningful Use

- The ONC defines the certification criteria for EHR *(how the EHR must work)*

- The CMS defines meaningful use *(how the EHR must be used)*

Achieving Meaningful Use

- Certification and meaningful use are not the same thing
    - Certification is what the EHR *can do* – responsibility of OIT
    - Meaningful Use is how the EHR *is used* – responsibility of providers and facilities
- You will *not* achieve meaningful use and obtain the incentives *only* by implementing a certified EHR
    - You must show you are using the certified EHR technology in a meaningful way

Achieving Meaningful Use

- **Exception:** The *first year* of the Medicaid incentives only require adopting, implementing, or upgrading to certified EHR technology and *do not require* the achievement of meaningful use. All other years require demonstration of meaningful use.

Achieving Meaningful Use (Continued)

- **What does it mean to adopt, implement, or upgrade?**
  - **Adopt:** Acquire and install the EHR
    - There must be evidence of actual installation prior to the incentive rather than "efforts" to install.
  - **Implement:** Start using the EHR
    - Includes staff training, data entry of patient data, or establishing data exchange agreements with other providers, such as laboratories, pharmacies, and health information exchanges.
  - **Upgrade:** Expand the functionality and start using a certified EHR that meets meaningful use requirements
    - Example: Add the ability to electronically verify insurance for all third party payors
    - Many IHS RPMS EHR sites will fall into the "upgrade" category.

Benefits of Meaningful Use

- Potential to improve quality and value of American healthcare

- Ability to share patient data with other providers and healthcare organizations

- Financial incentives to offset cost of EHR implementation and meaningful use

- Avoid the Medicare penalties that begin in 2015

Certification of RPMS

- Separate certifications are required for the RPMS EHR.

  - **Ambulatory:** RPMS EHR was certified in 2007 and will be recertified in 2010 or early 2011 under the new ambulatory criteria.

  - **Inpatient:** RPMS EHR will be certified in 2010 under the new Inpatient criteria.

- The RPMS EHR will support both certifications.

Overview of CMS Incentive Programs

EHR Incentive Programs

- Both Medicare and Medicaid will provide financial incentives for adopting and demonstrating meaningful use of certified EHR technology
  - Medicare incentives run 2011–2015.
  - Medicaid 2011–2021. However, *states are not required to participate in the program*. If they do not participate, providers and hospitals in the states will not receive incentive payments.
- Medicare will impose *penalties* beginning in 2015 for *not* meeting meaningful use.

EHR Incentive Programs (Continued)

- The incentives are available for users of *any certified EHR*, not just the RPMS EHR.
  - RPMS sites *must be using the EHR* to meet meaningful use. Sites only using RPMS *will not* meet meaningful use.
- Provider incentive programs begin in calendar year 2011.
- Hospital incentive programs begin in fiscal year 2011.
- To take maximum advantage of the incentives:
  - Providers need to be ready by January 1, 2011.
  - Hospitals need to be ready by October 1, 2010.

EHR Incentive Programs (Continued)

- **Medicare Incentives**
  - Providers and eligible hospitals *must meaningfully use certified EHR technology* for the EHR reporting period, defined as shown below.
    - **First Payment Year:** Any continuous 90-day period within the first payment year
    - **All Subsequent Payment Years:** The entire payment year

EHR Incentive Programs (Continued)

- **Medicaid Incentives**
  - In the first payment year only, providers and hospitals may receive an incentive payment by adopting, implementing, or upgrading certified EHR technology and *are not required to demonstrate meaningful use of such technology.*
    - They may choose to demonstrate meaningful use in the first payment year, but they are not required
  - In subsequent payment years, they *must demonstrate meaningful use* of such technology in order to receive a payment.

EHR Incentive Programs (Continued)

- There are two incentive programs applicable to IHS.
  - **Medicare Fee-for-Service Incentives**
    - Providers
    - Subsection (D) hospitals
    - Critical access hospitals (CAH)
  - **Medicaid Incentives**
    - Providers
    - Hospitals
- Providers may qualify for Medicare *or* Medicaid incentives, not both.
  - Providers may make a one-time change prior to 2015.
- Subsection (D) and acute care hospitals may qualify for both Medicare and Medicaid incentives.

EHR Incentive Programs (Continued)

- Not sure if your hospital is a Subsection (D), CAH, or acute care hospital?
  - The Meaningful Use Web site (see Contact Information slide) has a list of all federal and tribal hospitals and indicates if they are Subsection (D), CAH, and/or acute care.
  - The URL of this list is:

    http://www.ihs.gov/recovery/documents/IHS%20Federal%20and%20Tribal%20638%20Hospital%20List%20EB.pdf.

EHR Incentive Programs Summary

	MEDICARE		MEDICAID	
	Eligible Providers	**Hospitals**	**Eligible Providers**	**Hospitals**
Incentives Start	CY 2011	FY 2011	2011	2011
Incentives End	CY 2016 (max. 5 years)	FY 2015 (max. 4 years)	2021 (max. 6 years, must start by 2016)	2021 (max. 6 years, must start by 2016)
Incentive Amount	Up to $44,000 total per provider; based on % Medicare claims	Varies, depending on % Medicare inpatient bed days. CAHs paid based on EHR costs and % Medicare inpatient bed days	Up to $63,750 total per provider; based on 85% of EHR costs	Varies, depending on % Medicaid inpatient bed days
Reimbursement Reduced	CY 2015	FY 2015	No penalties	No penalties

Details of Incentive Programs

MEDICARE–Providers

Medicare Providers Program

- Medicare Providers Program
  - Must be a qualified non-hospital-based provider
  - Up to $44,000 per eligible Medicare provider, paid over 5 years
    - **Bonus:** Physicians practicing in a HPSA will receive increase of 10% (most I/T/U sites are in a HPSA)
      - >50% of the provider's covered Medicare services are furnished in a HPSA
  - Must use certified EHR technology and demonstrate meaningful use

Medicare Provider Eligibility Criteria (Continued)

- Eligible providers include non-hospital-based physicians, defined as:
  - Doctor of Medicine or Osteopathy
  - Doctor of Dental Surgery or Medicine
  - Doctor of Podiatric Medicine
  - Doctor of Optometry
  - Chiropractor
- A *hospital-based physician* is a provider, such as a pathologist, anesthesiologist, or emergency physician, who furnishes 90% or more of all their Medicare-covered professional services in a hospital setting through the use of facilities and equipment of the hospital.
  - If you bill with POS codes 21-Inpatient Hospital, 22-Outpatient Hospital, or 23-Emergency Room, Hospital on your physician claims, you are considered a hospital-based provider.

Medicare Provider Incentive Payment Breakdown

Maximum Incentive Payments Each Year							
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**TOTAL**
Adopt 2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	**$44,000**
Adopt 2012	----------	$18,000	$12,000	$8,000	$4,000	$2,000	**$44,000**
Adopt 2013	----------	----------	$15,000	$12,000	$8,000	$4,000	**$39,000**
Adopt 2014	----------	----------	----------	$12,000	$8,000	$4,000	**$24,000**
Adopt 2015 +	----------	----------	----------	----------	$0	$0	**$0**

Maximum payments are based on 75% of the provider's Medicare physician fee schedule allowed charges for CY 2011. For example, for payment year 2011 to receive the maximum $18,000 incentive payment, providers must have at least $24,000 of claims for covered professional services during Jan 1–Dec 31, 2011 and submitted on or before Feb 29, 2012. If you bill less, you are still able to participate but will receive smaller incentive payments.

(To determine the amount you must bill, divide the incentive payment by 0.75.)

Medicare Provider Incentives
Form and Timing of Payment

- Carriers/MACs will calculate the incentive payments.
- Single, consolidated annual incentive payment, made on a rolling basis.
  - Scenario 1: Provider Receives Maximum Incentive Payment.
    - As soon as it is determined that the provider demonstrates meaningful use during the reporting period and reaches the minimum threshold of allowable charges for claims during payment year for maximum payment
      - Includes claims for the payment year *and* submitted not later than two months after end of payment year
      - The Carrier/MAC would be authorized to disburse the full incentive payment

- Scenario 2: Provider Receives Less than Maximum Incentive Payment.
  - Provider does not bill enough in claims for the maximum payment.
  - Payment is calculated as [allowable charges based on claims for payment year] x 0.75.
    - For example, if total allowable charges were $10,000, incentive is calculated as $10,000 x 0.75.
    - Incentive payment is $7,500.
  - Payment is disbursed in the year following payment year.
- Payment is made after ensuring payment not made under Medicaid program.

Medicare Provider Incentives
Form and Timing of Payment (Continued)

- Providers *may not* receive both Medicare EHR incentive payments and e-Prescribing incentive payments.
  - Providers participating in the *Medicaid* incentive program may also receive e-Prescribing incentive payments.
- Payment will be made to the provider unless he/she has reassigned payment to an employer or facility.
  - Reassignment can only be made to one employer/facility.
- The NPI will be used to determine if a provider belongs to more than one practice.
- Providers with more than practice must select one TIN to receive any incentive payment.

Provider–Medicare Penalties Beginning in 2015

- Medicare Penalties
  - Beginning in 2015, providers that are not meaningful EHR users will have their Medicare physician fee schedule amount for covered professional services adjusted to equal the applicable fee schedule amount shown below.
    - 2015: 99% (1% reduction), if the provider is a successful electronic prescriber OR 98% (2% reduction) if they are *not* a successful electronic prescriber
    - 2016: 98% (2% reduction)
    - 2017+: 97% (3% reduction)
    - 2018+: If the Secretary finds fewer than 75% of providers are meaningful EHR users, an additional decrease of 1% from prior year but no less than 95%

Provider–Medicare Penalties (Continued)

- The HITECH Act includes a significant hardship exception.
  - Example: Provider practices in rural area without sufficient Internet access
  - Subject to annual renewal
  - Maximum exemption of five years
- Hospital-based providers are exempt from the penalties.

MEDICARE–Hospitals

Medicare Hospital Eligibility Criteria

- Eligible hospitals include
  - Subsection (D) hospitals that either receive reimbursement for services under Medicare FFS program or are affiliated with a qualifying Medicare Advantage organization
    - Generally is a hospital located in one of the 50 states or the District of Columbia
      - Includes inpatient, acute care hospitals in the State of Maryland not currently paid under the Inpatient Prospective Payment System
    - Excludes psychiatric, rehabilitation, long-term care, children's, and cancer hospitals
  - CAH

Subsection (D) Hospitals–Medicare Incentives

- **Subsection (D) Hospitals**
  - Incentives run 2011–2016
  - Maximum participation of 4 years per hospital
  - Must start no later than 2015
  - Hospitals that start by 2013 will receive the maximum incentives
  - Incentive Payment Calculation

Incentive Amount =

[Initial Amount] x [Medicare Share] x [Transition Factor]

- **Initial Amount** = Base Amount + Discharge-Related Amount, where
  - Base Amount = $2,000,000
  - Discharge-Related Amount: The sum of the amount estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the FY prior to the payment FY, for each discharge up to the 23,000th discharge, as follows:
    - 1st–1,149th discharge: $0
    - 1,150th–23,000th discharge: $200
    - >23,000th discharge: $0

Subsection (D) Hospitals– Medicare Incentives (Continued)

- Sample Calculation Initial Amount for 2011 Payment Year

  - Your hospital has 50 discharges per week in FY 2010 (i.e. July 1, 2009–June 30, 2010)

50 discharges x 52 weeks = 2,600 discharges

2,600 discharges – 1,149 discharges (base) = 1,451

1,451 discharges x $200 (incentive payment) = $290,200

Initial Amount = $2,000,000 (base amount) + 290,200 (discharge-related amount) **= *$2,290,200***

Subsection (D) Hospitals – Medicare Incentives (Continued)

- **Medicare Share** = $M/(T*C)$, where
  - M = [# of inpatient bed days for Part A Beneficiaries] +

    [# of inpatient bed days for MA (Part C)

    Beneficiaries]
  - T = [# of total inpatient bed days]
  - C = [Total charges – charges for charity care] /

    [Total charges]

  If data on charity care is not available, data on uncompensated care is used as a proxy. Otherwise, it would be equal to 1.

- Charity Care
  - Part of uncompensated and indigent care described for Medicare cost reporting purposes in the Medicare cost report instructions at section 4012 of the Provider Reimbursement Manual, Part 2; Worksheet S-10; Hospital Uncompensated and Indigent Care Data.
    - Subsection (D) hospitals and CAHs are required to complete the Worksheet S-10, which is being revised to include a definition of charity care.
  - Hospitals should use the same charity care charges that they will report on Line 19 of the revised Worksheet S-10.

Subsection (D) Hospitals – Medicare Incentives (Continued)

- Sample Calculation of Medicare Share for Payment Year 1
  - Assumptions
    - 2,600 annual discharges, average length of stay of 4 days, average cost/inpatient stay of $8,500, Medicare population of 5% where 80% have Part A and 20% have Part C coverage, and 5% charity care
  - # inpatient bed days: 10,400
    - # days for Part A beneficiaries: 416
    - # days for MA (Part C) beneficiaries: 104
  - Total charges: $22,100,000
    - Total charges for charity care: $1,105,000
  - M = [416 (# Part A days) + 104 (# MA days)] = 520
  - T = 10,400 (# inpatient bed days)
  - C = .95 [($22,100,000 (total charges) – $1,105,000 (charity care charges))/$22,100,000 (total charges)]
  - MS = [M / (T * C)]
  - **MS** = [520 / (10,400 * .95) **= 0.053**

Subsection (D) Hospitals – Medicare Incentives (Continued)

- Transition Factor for Medicare FFS Eligible Hospitals

Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	-----	-----	-----	-----
2012	0.75	1.00	-----	-----	-----
2013	0.50	0.75	1.00	-----	-----
2014	0.25	0.50	0.75	0.75	-----
2015	-----	0.25	0.50	0.50	0.50
2016	-----	-----	0.25	0.25	0.25

- **Sample Calculation of Incentive Payment for Payment Year 1**
  - Initial Amount: $2,290,200
  - Medicare Share: 0.053
  - Transition Factor for Payment Year 1: 1
  - Incentive Amount = Initial Amount x Medicare Share x Transition Factor
  - Incentive Amount = $2,290,200 x 0.053 x 1
  - *Incentive Amount for Payment Year 1 = $121,381*

Medicare Subsection (D) Incentives
Form and Timing of Payment

- FIs/MACs will calculate the incentive payments.

- Payments disbursed on an interim basis after hospitals have demonstrated meaningful use during the reporting period for the payment year.

- Will use the prior-year cost report, PS&R system data, and other estimates to calculate the interim incentive payment.

- Payment is calculated based on the CCN of the main provider.

- Payment is disbursed based on the CCN.

- Final payments determined at time of settling the hospital cost report for the hospital FY that ends during the payment year.

Subsection (D) Hospitals – Medicare Penalties Beginning in 2015

- Beginning in 2015, market basket updates to the IPPS payment rate will be adjusted downward for hospitals that are not meaningful users.

  - ¼ reduction for not submitting quality measure data, *and*

  - ¼ reduction in 2015, ½ reduction in 2016, and ¾ reduction in 2017+ for not achieving meaningful use

SAMPLE CALCULATION of Payment Adjustments Assumes a market basket update of 2.0% all Fiscal Years				
Fiscal Year	**Hospital's Status on Reporting Quality Data and Achieving Meaningful Use (MU)**			
	MU + Quality Data	MU – No Quality Data	Quality Data – No MU	No MU and No Quality Data
2015	2.0%	1.5%	1.5%	1.0%
2016	2.0%	1.5%	1.0%	0.5%
2017+	2.0%	1.5%	0.5%	0.0%

Subsection (D) Hospitals– Medicare Penalties (Continued)

- The information below needs to be confirmed with CMS (it is referred to in the CAH section but is not included in the Subsection D part of the CMS proposed rule).
  - Significant hardship exception
    - Example: Hospital is located in rural area without sufficient Internet access
    - Subject to annual renewal
    - Maximum exemption of five years

CAHs–Medicare Incentives

- **CAHs**
  - Incentive payments are made to a qualifying CAH for the reasonable costs incurred for the purchase of certified EHR technology in a cost reporting period beginning during a payment year occurring FY 2011–FY 2015.
  - A CAH may receive incentive payments for no more than four consecutive payment years.
  - If the first payment year is FY 2013, the fourth payment year occurs in 2016 and payment will not be paid since incentives cease in FY 2015.

CAHs–Medicare Incentives (Continued)

- A *Qualifying CAH* is a CAH that meets the meaningful EHR user definition for eligible hospitals.

- *Reasonable costs* for the purchase of certified EHR technology include:

  - Reasonable acquisition costs, excluding any depreciation and interest expenses associated with the acquisition, incurred for the purchase of depreciable assets, such as computers and associated hardware and software, necessary to administer the technology

CAHs–Medicare Incentives (Continued)

- The CAH must submit supporting documentation for its incurred costs of purchasing certified EHR technology to its Medicare contractor (FI/MAC).
    - The Medicare contractor will review the CAH's current year and each subsequent year's cost report to ensure the assets associated with the acquisition are expensed in a single period and that depreciation and interest expenses associated with the acquisition are not allowed.

- **Incentive Payment Calculation**

[(Reasonable costs incurred in that cost reporting period)

+

(Similarly incurred costs from previous cost reporting periods to the extent they have not been fully depreciated as of the cost reporting period involved)]

x

[CAH's Medicare Share + 20 percentage points]

NOTE: Medicare Share is calculated the same way as shown previously for Subsection (D) hospitals. When the 20 percentage points are added, the total cannot be more than 100%.

CAHs–Medicare Incentives (Continued)

- Sample Calculation for 2012 Payment Year for a Qualifying CAH
  - Costs incurred in current cost reporting period beginning in FY 2012 that will not be depreciated:
    - Purchased certified EHR for $300,000 in current cost reporting period beginning Jan 1, 2012
    - *Current Costs Amount: $300,000*

CAHs–Medicare Incentives (Continued)

- Sample Calculation for 2012 Payment Year for a Qualifying CAH (Continued)
  - Costs incurred in previous cost reporting period not fully depreciated:
    - Purchased certified EHR for $500,000 in previous cost reporting period beginning Jan 1, 2011
    - Depreciated $100,000 of the costs in previous cost reporting period beginning Jan 1, 2011
    - *Previous Costs Amount: $400,000*
      [Reasonable cost of $500,000] – [Depreciated cost of $100,000]
  - **Recalculated Medicare Share: 0.253** (this example assumes the CAH's calculated Medicare Share is the same (0.053) as shown in the prior example for subsection (D) hospitals) (0.053 + 0.20)

CAHs–Medicare Incentives (Continued)

- Sample Calculation for 2012 Payment Year for a Qualifying CAH (continued)

[($300,00 Costs in Current Cost Reporting Period)

+

($400,000 Undepreciated Costs in Previous Cost Reporting Periods)]

x

[Recalculated Medicare Share of 0.253]

=

2012 Incentive Payment Amount: $177,100

Medicare CAH Incentives
Form and Timing of Payment

- CAHs are paid on a cost reimbursement basis.

- Once a CAH incurs actual EHR costs, it can submit supporting documentation to the FI/MAC for review.

  - FIs/MACs will reconcile the cost report and ensure EHR expenses are adjusted on the cost report to avoid duplicate payments.

  - Incentive payments are calculated and disbursed based on the CCN of the main provider.

CAHs–Medicare Penalties Beginning in 2015

- Current Reimbursement Method.
  - CAHs are currently reimbursed at 101% of reasonable costs of furnishing Medicare-covered services to beneficiaries.
- Beginning in 2015, CAHs that are not meaningful EHR users will have their reimbursements adjusted, as shown below.
  - 2015: 100.66% (.34% reduction)
  - 2016: 100.33% (.67% reduction)
  - 2017+: 100% (1.00% reduction)
- Significant hardship exception:
  - Example: CAH is located in rural area without sufficient Internet access
  - Subject to annual renewal
  - Maximum exemption of five years

Medicare Incentive Program Compliance Reviews

- CMS will conduct selected compliance reviews of providers, Subsection (D) hospitals, and CAHs that receive incentive payments.

- The reviews will:
  - Validate provider eligibility
  - Verify meaningful use attestations and review
  - Review components of the payment formulas

- If an overpayment is identified, CMS will *recoup the payment.*

- Providers and hospitals must maintain evidence of qualification to receive incentive payments for *10 years* after the date they register for the incentive program.

MEDICAID–Providers

Medicaid Provider Eligibility Criteria

- Eligible providers include non-hospital-based providers defined as any of the following *except* for any provider shown below practicing predominantly[†] in a FQHC or RHC

  - Physicians
  - Dentists
  - Certified Nurse-Midwives
  - Nurse Practitioners
  - Physician Assistants who are practicing in FQHCs or RHCs led by a physician assistant

- A *hospital-based provider* is defined as a provider who furnishes 90% or more of their covered professional services in a hospital setting (inpatient, outpatient, or emergency room; Place of Service codes 21, 22, or 23 on physician claims).

[†] When over 50% of total patient encounters over a period of 6 months occurs at an FQHC or RHC.

Additional Medicaid Provider Eligibility Criteria

- **Medicaid patient volume requirements**

Provider/Hospital	Minimum 90-Day Medicaid Patient Volume Threshold	Or if the Medicaid-Eligible Provider practices predominately in an FQHC or RHC – 30% "Needy individuals" patient volume threshold
Physicians	30%	
Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Physician Assistants (when practicing at an FQHC/RHC led by a physician assistant)	30%	
Nurse Practitioner	30%	
Acute Care Hospital	10%	**N/A**
Children's Hospitals	None	

Additional Medicaid Provider Eligibility Criteria (Continued)

- **Additional information on patient volume requirements**

Medicaid Patient Volume Requirements	
Provider Type	**Patient Volume Requirement**
• Non-hospital-based physicians, dentists, certified nurse midwives, nurse practitioners • PAs practicing at an FQHC/RHC led by a PA	• >=30% of all patient encounters attributable to Medicaid over any continuous 90-day period in the most recent CY prior to reporting • >=20% for pediatricians
• Any of the above practicing predominantly in an FQHC or RHC (when the FQHC/RHC is the clinical location for over 50% of total encounters for 6 months in the most recent CY)	• >=30% of all patient encounters attributable to "needy individuals" over any continuous 90-day period in the most recent CY prior to reporting • "Needy individuals" include: Medicaid or CHIP enrollees, patients furnished uncompensated care by the provider, or furnished services at no cost or on a sliding scale.

Medicaid Provider Incentive Payments

- Incentive payments run 2011–2021.

- Not required to participate on a consecutive annual basis.

- Providers can start as late as 2016 and still receive the maximum payments.

- In the first year of the program:

  - Providers who adopt, implement, or upgrade certified EHR technology are not required to demonstrate meaningful use.

    - *IHS anticipates RPMS EHR users would fall into this category.*

Medicaid Provider Incentive Payments (Continued)

- States that are ready may make EHR incentive payments in *2010* to providers that adopt, implement, or upgrade certified EHR technology after the *final rule* has been released.
  - Must require provider to verify he/she is not accepting payment in any other state
  - Must have electronic system for provider registration and transmit the information to CMS
  - Payments would *not* be made for meaningful users
    - Intended to give providers opportunity for capital (money) for an EHR

Medicaid Provider Incentive Payments (Continued)

- Incentive payment calculation
  - Payment equals 85% of net average allowable costs.
  - Maximum net average allowable costs:
    - 1st Year: $25,000*
      - Costs for hardware, software, implementation and training, and costs associated with productivity that occur in early stages of implementation
    - 5 Subsequent Years: $10,000 each year*
      - Costs for operating and maintaining the system, including: software licensing fees, technical support, and updating and replacing used equipment.

* Pediatricians with less than 30% Medicaid patient volume receive 2/3 of these amounts.

Medicaid Provider Incentive Payments (Continued)

- Incentive payment calculation (continued)
  - Total maximum payments*
    - First Year: $25,000 (net average allowable cost) x .85 = $21,250
    - 5 Subsequent Years: $10,000 (net average allowable cost) x .85 x 5 = $42,500
    - Total Maximum Payment: $63,750
      - **Exception:** Pediatricians with Medicaid patient volume >=20% and <30%
        - 1st year: (2/3 x $25,000 = $16,666) x .85 = $14,166
        - Subsequent years: [(2/3 x $10,000 = $6,667) x 5 years x .85] = $33,335 x .85 = $28,334
        - Total Maximum Payment: $42,500

Medicaid Provider Incentive Payments (Continued)

- Incentive payment calculation (continued)
  - Net average allowable costs
    - To determine "*net*" average allowable costs, must subtract any payment the provider received for certified EHR technology or services
      - EXCEPTION: Payments from state or local governments do not reduce the average allowable costs.

Medicaid Provider Incentive Payments (Continued)

- Incentive payment calculation (continued)
  - Net average allowable costs, Example 1:
    - First year EHR cost: $75,000
    - Federal grant received for EHR cost: $50,000
    - State or local government grant for EHR cost: $15,000 (N/A; does not reduce the costs)
    - Net average allowable costs calculation:
      $75,000 – $50,000 = $25,000 (net average allowable cost)
    - Since $25,000 = the maximum, provider would receive 85% of $25,000 or $21,250 in Year 1

Medicaid Provider Incentive Payments (Continued)

- Incentive payment calculation (continued)
  - Net average allowable costs, Example 2
    - First year EHR cost: $30,000.
    - Federal grant received for EHR cost: $10,000.
    - State or local government grant for EHR cost: $15,000 (N/A; does not reduce the costs).
    - Net average allowable costs calculation:
      $30,000 – $10,000 = $20,000.
    - Provider would receive 85% of $20,000 or $17,000 in Year 1.

Medicaid Provider Incentive Payments (Continued)

Payments for Providers Who Begin Adoption *or* Who Are Meaningful Users in First Year

Calendar Year	Medicaid Providers Who Begin Adoption *or* Begin MU In:					
	2011	2012	2013	2014	2015	2016
2011	$21,250	--------------	--------------	--------------	--------------	--------------
2012	$8,500	$21,250	--------------	--------------	--------------	--------------
2013	$8,500	$8,500	$21,250	--------------	--------------	--------------
2014	$8,500	$8,500	$8,500	$21,250	--------------	--------------
2015	$8,500	$8,500	$8,500	$8,500	$21,250	--------------
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	--------------	$8,500	$8,500	$8,500	$8,500	$8,500
2018	--------------	--------------	$8,500	$8,500	$8,500	$8,500
2019	--------------	--------------	--------------	$8,500	$8,500	$8,500
2020	--------------	--------------	--------------	--------------	$8,500	$8,500
2021	--------------	--------------	--------------	--------------	--------------	$8,500
TOTAL:	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Medicaid Provider Form and Timing of Payments

- Providers who practice in multiple states must choose only one state from which to receive a Medicaid incentive payment.

  - May change the state they select each year

- States will disburse payments to providers in alignment with the calendar year.

- States will process payments on a rolling basis.

- CMS is considering an alternative plan where providers who have already adopted, implemented, or upgraded EHR *would not* receive the first year payment of $21,250 for EHR costs.

MEDICAID–Hospitals

Medicaid Hospital Eligibility Criteria

- Eligible hospitals include
  - Acute care hospitals
    - A healthcare facility where the average length of patient stay is 25 days or fewer *and* that has a CCN in the range of 0001–0879
      - Includes short-term general hospitals and the 11 cancer hospitals in the U.S.
  - Children's hospitals
    - Must have a CCN in the range of 3300–3399
    - Predominantly treats individuals under 21 years of age

Medicaid Hospital Eligibility Criteria (Continued)

Medicaid Patient Volume Requirements	
Hospital	**Patient Volume Requirement**
• Acute care hospitals	• >=10% of all patient encounters attributable to Medicaid over any continuous 90-day period in the most recent CY prior to reporting
• Children's hospitals	• None

- **Incentive Payment Calculation**

  - Based on an *aggregate EHR hospital incentive amount*, which is the total amount the hospital could receive in Medicaid payments over four years of the program

  Aggregate EHR hospital incentive amount = [Overall EHR Amount] x [Medicaid Share]

- **Overall EHR Amount =**

{Sum over 4 years of

[(Base Amount of $2,000,000

\+

Discharge-Related Amount Applicable for Each Year)

x

Transition Factor Applicable for Each Year]}

Medicaid Hospital Incentive Payments (Continued)

- Discharge-Related Amount
    - $200 per discharge for discharges 1,150–23,000.
    - To determine discharge related amount for the three subsequent payment years, states should assume discharges for a hospital have increased by the average annual growth rate for the hospital over the most recent three years of available data from an auditable data source.
        - If a hospital's average annual growth rate is negative over the three-year period, it should be applied as such.

Medicaid Hospital Incentive Payments (Continued)

- Discharge-Related Amount (continued)
  - Sample Calculation
    - Assumptions
      - Hospital had 2,600 discharges in the first FY (2011)
      - Most recent growth data as follows
        - FY 2005 (.028 annual growth rate)
        - FY 2006 (.013 annual growth rate)
        - FY 2007 (.027 annual growth rate)

        Average annual growth rate over 3 years: .0227

Medicaid Hospital Incentive Payments (Continued)

- Discharge-Related Amount (continued)
  - Sample Calculation (continued)
    - <u>Year 1 Discharge-Related Amount</u>

      (2,600 – 1,149) x $200 = $290,200
    - <u>Year 2 Discharge-Related Amount</u>

      2,600 x 1.0227 = 2,659

      (2,659 – 1,149) x $200 = $302,000
    - <u>Year 3 Discharge-Related Amount</u>

      2,659 x 1.0227 = 2,719

      (2,719 – 1,149) x $200 = $314,000
    - <u>Year 4 Discharge-Related Amount</u>

      2,719 x 1.0227 = 2,781

      (2,781 – 1,149) x $200 = $326,400

Medicaid Hospital Incentive Payments (Continued)

- Transition Factor

Consecutive Payment Year	Transition Factor
1	1
2	¾
3	½
4	¼

Medicaid Hospital Incentive Payments (Continued)

- *Medicaid Share* is the percentage of a hospital's inpatient, noncharity care days that are attributable to Medicaid patients.
  - *Medicaid Share = M/(T*C)*, where
    - M = [# of Medicaid inpatient bed days] +
      [# of Medicaid managed care inpatient bed days]
    - T = [# of total inpatient bed days]
    - C = [Total charges – charges for charity care] /
      [Total charges]
  - If data on Medicaid managed care inpatient bed days is not available, it will be equal to 0.
  - If data on charity care is not available, data on uncompensated care is used as a proxy. Otherwise, it would be equal to 1.

- Charity Care
  - States should use the revised Medicare 2552-10, Worksheet S-10 or another auditable data source to determine the charity care portion of the formula.
  - In absence of sufficient charity care data to complete the calculation, Section 1886(n)(2)(D) of the Act requires the use of uncompensated data to derive an appropriate estimate of charity care, including a downward adjustment for bad debts, per the Medicare definition of bad debt as promulgated at 42 CFR 413.89(b)(1).

Medicaid Hospital Incentive Payments (Continued)

- Sample Calculation of Medicaid Share
  - Assumptions
    - 2,600 annual discharges, average length of stay of 4 days, average cost/inpatient stay of $8,500, Medicaid population of 35% where 100% have Medicaid FFS and 0% have Medicaid Managed Care Coverage, and 5% charity care
  - # inpatient bed days: 10,400
    - # days for Medicaid FFS beneficiaries: 3,640
    - # days for Medicaid Managed Care beneficiaries: 0
  - Total charges: $22,100,000
    - Total charges for charity care: $1,105,000
  - M = [3,640 (# Medicaid FFS days) + 0 (# Medicaid Managed Care days)] = 3,640
  - T = 10,400 (# inpatient bed days)
  - C = .95 [($22,100,000 (total charges) – $1,105,000 (charity care charges)) / $22,100,000 (total charges)]
  - MS = [M / (T * C)]
  - **MS** = [3,640 / (10,400 * .95)] **= 0.37**

Medicaid Hospital Incentive Payments (Continued)

- Sample Calculation of Overall EHR Amount
  - Overall EHR Amount = Sum (Year 1, Year 2, Year 3, Year 4)
    - Year 1: {$2,000,000 + ((2,600-1,149) x 200)} x 1 = $2,290,200
    - Year 2: {$2,000,000 + ((2,659-1,149) x 200)} x .75 = $1,726,500
    - Year 3: {$2,000,000 + ((2,719-1,149) x 200)} x .50 = $1,157,000
    - Year 4: {$2,000,000 + ((2,781-1,149) x 200)} x .25 = $581,600
  - Overall EHR Amount = $5,755,300

Medicaid Hospital Incentive Payments (Continued)

- *Sample Calculation of Medicaid Aggregate EHR Incentive Amount*
  - Overall EHR Amount: $5,755,300
  - Medicaid Share: 0.37
  - Medicaid Aggregate EHR Incentive Amount = Overall EHR Amount x Medicaid Share
  - Medicaid Aggregate EHR Incentive Amount = $5,755,300 x 0.37
  - *Medicaid Aggregate EHR Incentive Amount = $2,129,461*

Medicaid Hospital Incentive Payments (Continued)

- **Incentive Payments**
  - The last year a hospital may *begin* receiving Medicaid incentive payments is FY 2016.
  - *States must make payments over a minimum of three years and a maximum of six years.*
  - In any given payment year, no annual Medicaid incentive payment may exceed 50% of the hospital's aggregate incentive payment.
  - Over a two-year period, no Medicaid payment to a hospital may exceed 90% of the aggregate incentive.

Stage 1 Meaningful Use Standards and Measures (for 2011–12)

- Functional and Interoperability Measures
- Clinical Quality Measures

Functional and Interoperability Measures

Functional and Interoperability Measures Summary

- **Ambulatory (Providers)**
  - To be a meaningful user, providers must have 50% of more of their patient encounters during the reporting period at a facility equipped with a certified EHR.
    - If not met at a single facility, must be met with a combination of practices
  - 25 measures:
    - 8 measures require Yes or No answer
    - 17 measures require numerator and denominator

- **Inpatient (Hospitals)**
  - 23 measures:
    - 10 measures require Yes or No answer
    - 13 measures require numerator and denominator
  - The measures apply only to a hospital's inpatient setting.

Functional and Interoperability Measures Summary (Continued)

- **All-or-Nothing Approach**
  - Providers and hospitals must meet the objectives for *all* measures in order to achieve meaningful use.
    - Most measures have established targets that *must* be met.
- **Reporting Periods for Measures**
  - First year: Continuous 90-day period
  - All other years: Entire year

Functional and Interoperability Measures

- Computerized Provider Order Entry
  - Ambulatory–at least 80% of all orders must be entered directly into EHR by the provider
  - Inpatient–at least 10% of all orders must be entered directly into EHR by the provider
- Drug-drug, drug-allergy, drug-formulary checks
  - All sites must implement these features of EHR.
- Problem Lists
  - At least 80% of patients (inpatient and outpatient) must have a current Problem List (or notation of no problems).

Functional and Interoperability Measures (Continued)

- Electronic Prescribing
  - At least 80% of prescriptions must be entered and transmitted electronically.

- Medication Lists
  - At least 80% of inpatient and outpatients must have a medication list documented in the EHR (or notation of no medications).

- Documentation of Allergies
  - At least 80% of inpatients and outpatients must have drug allergies documented in the EHR (or notation of no allergies).

Functional and Interoperability Measures (Continued)

- Recording Demographic Information
  - At least 80% of inpatients and outpatients have specific demographic information recorded in RPMS.

- Recording Vital Measurements
  - At least 80% of inpatients and outpatients age 2 and older have vital measurements recorded in EHR, including growth charts for children.

- Recording Smoking Status
  - At least 80% of inpatients and outpatients age 13 and older have their smoking status recorded in the EHR.

Functional and Interoperability Measures (Continued)

- Incorporate laboratory test results into EHR
  - At least 50% of all laboratory tests have their results recorded in the EHR.
- Generate lists of patients with specific conditions
  - Generate at least one report from the EHR listing patients with a specific condition.
- Ability to report on meaningful use quality measures
  - 2011 – manual submission of data to CMS
  - 2012 – electronic submission of data to CMS

Functional and Interoperability Measures (Continued)

- Send reminders to patients for preventive/follow-up care, per patient preference (internet or non-Internet)
  - Each eligible provider must send reminders to at least 50% of their outpatients age 50 and older.
- Clinical decision support rules
  - Implement at least five clinical decision support rules that are linked to the clinical quality measures.
- Electronic insurance verification
  - At least 80% of outpatients and inpatients have insurance eligibility checked electronically.
- Electronic claims submission
  - At least 80% of insurance claims are filed electronically.

Functional and Interoperability Measures (Continued)

- Provide information to patients
  - At least 80% of outpatients and inpatients who request electronic copies of health records receive them within 48 hours.
  - At least 80% of discharged patients are provided electronic copies of procedure reports and discharge instructions upon request.
- Provide patients timely access to health information
  - At least 10% of patients can get electronic access to lab results, problem, medication and allergy lists within 96 hours after they are available to the provider (e.g. Personal Health Record).
- Clinical summaries of office visits
  - Clinical summaries are provided for at least 80% of office visits.

Functional and Interoperability Measures (Continued)

- Ability to exchange data with other systems
    - Perform a test of system's ability to exchange key clinical information electronically, such as problem and medication list, diagnostic test results, etc.
- Medication Reconciliation
    - Perform medication reconciliation for at least 80% of inpatient/outpatient encounters and transitions of care.
- Summary of care record
    - Provide a summary of care for at least 80% of inpatient/outpatient referrals and transitions of care.
        - Includes key information about the patient, such as diagnostic test results, problem and medication list, etc.

Functional and Interoperability Measures (Continued)

- Immunization Registries
  - Perform test of system's ability to transmit immunization information to registries
- Reportable Lab Results
  - Perform test of system's ability to send reportable lab results to public health agencies (hospitals only)
- Surveillance Data
  - Perform test of system's ability to electronically send "syndromic surveillance data" to public health agencies
- Privacy and Security
  - Conduct a security risk analysis of EHR system

2011 Reporting of Functional and Interoperability Measures

- For Medicare incentives, performance on measures will reported by providers and hospitals through attestation via claims based reporting or an online portal, which must include:

  - **Identify the certified EHR they are using**

  - **Results of all performance measures**

  - **Measures that report a percentage:** Submit numerator and denominator data to CMS

  - **Measures that report a Yes or No answer:** Attestation (verification) that the EHR possesses the functionality or that the test has been performed

Clinical Quality Measures

Clinical Quality Measures Summary

- **Provider measures:**
  - Three core measures
  - 3–5 measures according to provider's specialty
- **Hospital measures:**
  - Required to report on 35 Medicare measures
    - For Medicaid, hospitals have the option to report on 8 alternative Medicaid measures if the 35 measures do not apply to their patient population.
- For both provider and hospital measures, measures must be reported on *all patients*, not just Medicare and Medicaid.

Measure Selection

- The Secretary is required to *give preference* to measures endorsed by the NQF, including the PQRI measures or measures previously selected for the RHQDAPU program.

- However, the Secretary is *not required* to use the NQF endorsed measures or limit them to those included in RHQDAPU or PQRI programs.

Measure Selection (Continued)

- Medicaid measures will be aligned to the extent possible with the measures selected under the CHIPRA measure set.

Measure Specifications

- Once the CMS final guidelines are published, *no additions or deletions of measures* will be made except through further rulemaking.

- Revisions to the measures, such as code additions, corrections, etc., may be made for the 2011 and 2012 payment year measures.

Measure Specifications Publication Dates

- **2011 payment year for Medicare hospital measures:** Included in the CMS Final Rule

- **2012 payment year for Medicare provider measures:** April 1, 2011

- **To be clarified with CMS:** Publication dates for specifications for:

  - 2011 Medicare provider measures

  - 2012 Medicare hospital measures

  - 2011 and 2012 Medicaid provider and hospital measures

Quality Measures Reporting Goal

- Goal is for providers and hospitals to use EHRs to transmit clinical quality measures to the Secretary for Meaningful Use that would also be used for other reporting programs such as PQRI and RHQDAPU.

  - Measures would only need to reported once, which complies with statutory requirement to avoid duplicate reporting.

Provider Measures (same measures for both Medicare and Medicaid incentive programs)

Provider Core Measures

- **Providers must report on three core measures**
  - **Preventive Care and Screening: Inquiry Regarding Tobacco Use (PQRI #114, NQF #0028)**
    - Percentage of patients 18+ queried about tobacco use one or more times within 24 months
  - **Blood Pressure Measurement (NQF #0013)**
    - Percentage of patient visits with BP measurement recorded among all patient visits for patients aged >18 years with diagnosed hypertension

Provider Core Measures (Continued)

- **Drugs to be Avoided in the Elderly (NQF #0022) (two measures)**
  - Percentage of patients 65+ who received at least one drug to be avoided in the elderly in the measurement year
  - Percentage of patients 65+ who received at least two different drugs to be avoided in the elderly in the measurement year

Provider Specialty Measures

- Each provider must report on 3–5 measures in one of the specialty groups shown below.

- IHS will assign priority to the groups in bold below in the event it is not able to add all of the measures to RPMS in time for Stage 1 reporting.

Cardiology	Neurology
Pulmonology	Psychiatry
Endocrinology	Ophthalmology
Oncology	Podiatry
Proceduralist/Surgery	Radiology
Primary Care Physicians	Gastroenterology
Pediatrics	Nephrology
OB/GYN	

Examples of Provider Specialty Measures

- Examples of Primary Care Physicians group measures

  - **Preventive Care and Screening: Colorectal Cancer Screening (NCQA measure)**

    - Percentage of patients ages 50 through 80 years who received the appropriate colorectal cancer screening

  - **Cervical Cancer Screening (NCQA measure)**

    - Percentage of women 18–64 years of age who received one or more Pap tests during the measurement year or the 2 years prior to the measurement year

Provider Specialty Measures (Continued)

- The same specialty measures selected for the first payment year are required to be reported for the second payment year.

- If no specialty groups apply to the provider, the provider must:

  - Attest to the inapplicability of specialty groups to CMS or the state

  - Report on the three core measures

Hospital Measures

Medicare and Medicaid Hospital Measures Reporting Criteria

- Starting with the 2011 payment year, hospitals must report by attestation on 35 inpatient measures for Medicare.
  - If none of the measures apply, can report on 8 Medicaid measures.
  - No reporting is required in the first year for the *Medicaid* incentives.
- For 2012, hospitals must report electronically on the Medicare measures.
  - The CMS proposed rule contains contradictory statements on whether or not the Medicare measures will suffice for both Medicare and Medicaid incentives or if additional measures are required for the Medicaid incentives.

Examples of Hospital Medicare Measures

- **Examples of Hospital Measures–Medicare**
  - **Ischemic Stroke–Discharge on Antithrombotics**
    - Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge
  - **Ischemic stroke–Discharge on statins**
    - Ischemic stroke patients with LDL >100 mg/dL, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge

Examples of Hospital Medicaid Measures (Continued)

- **Examples of Hospital Measures–Medicaid**
  - **Pneumonia Care Antibiotic**
    - Percentage of pneumonia patients 18 years of age and older who receive their first dose of antibiotics within 6 hours after arrival at the hospital
  - **PICU Pain Assessment on Admission**
    - Percentage of PICU patients receiving:
      - Pain assessment on admission
      - Periodic pain assessment

2011 Reporting of Quality Measures

- **Medicare:** Providers and hospitals must submit summary information on the quality measures to CMS and verify the information was reported through a certified EHR.

- **Medicaid:** Providers and hospitals are *not* required to submit summary information to CMS or the states.

  - Will qualify for payment by adopting, implementing, or upgrading to certified EHR technology

- **Providers—Medicare Quality Measure Reporting Requirements**
  - Must verify the quality measures information:
    - Was generated from a certified EHR
    - Is accurate
    - Includes information for *all* patients
  - Provider's NPI, TIN, and specialty group of clinical measures.
  - If applicable, verify that one or more core measures do not apply.
  - If applicable, verify that none of the specialty groups apply.
  - If applicable, verify that one or more specialty measures do not apply.

- **Providers–Medicare Quality Measure Reporting Requirements (continued)**
  - Numerators, denominators, and exclusions for each quality measure, for
    - All patients
    - Medicare FFS patients
    - Medicare Advantage patients
    - Medicaid patients
  - Report period beginning and end dates

- **Hospitals–Medicare Quality Measure Reporting Requirements**
  - Must verify the quality measures information:
    - Was generated from a certified EHR
    - Is accurate
    - Includes information for *all* patients
  - Hospital's identifying information (CCN).
  - If applicable, verify that one or more measures do not apply.
  - Numerators, denominators, and exclusions for each quality measure, for:
    - All patients
    - Medicare FFS patients
    - Medicare Advantage patients
    - Medicaid patients
  - Report period beginning and end dates.

2012 Reporting of Quality Measures

- **Medicare and Medicaid**, providers and hospitals must submit summary information (i.e., not personally identifiable) *electronically* to receive the incentive payments
  - Requires the Secretary to be ready to accept the electronic information.
  - Providers and hospitals that are eligible *only* for Medicaid incentives will report their quality data to the state.
    - States will propose to CMS how they plan to accept and validate the data in their State Medicaid HIT Plans, subject to CMS approval.

2012 Reporting of Quality Measures (Continued)

- **Data will be reported using one of three methods**
  - CMS-designated portal through an upload process such as CDA from the certified EHR
  - HIE/HIO
    - Dependent on the Secretary's ability to collect data through an HIE/HIO network
    - Requires provider/hospital to be a participating member of the HIE/HIO
    - Requires data to be based on structures such as CDA
  - Registries
    - Dependent on development of this functionality
  - Requirements for the methods to be posted by
    - April 1, 2011 for hospitals
    - July 1, 2011 for providers

OIT, Area, and Facility Responsibilities for Achieving Meaningful Use

Meaningful Use Requires a Team Effort

- Achievement of meaningful use will require a coordinated effort between OIT, the Area Offices, and the I/T/U facilities.

- As described in the next sections, each of us have our own part to play to meet the requirements for meaningful use .

- The timeframe for actual achievement of meaningful use is dependent on getting RPMS EHR certified but in the meantime, there are many advance activities that need to be started now.

OIT Responsibilities

- Research and understand meaningful use requirements
- Communicate meaningful use requirements to IHS, Tribal, and Urban facilities and leadership
- Ensure that the RPMS EHR:
  - Includes all changes needed to support meaningful use
  - Includes new reports for reporting of (1) functional and interoperability and (2) clinical quality measures
  - Is certified as both an outpatient and inpatient EHR
  - Is deployed in time for facilities to be able to meet meaningful use in 2011

Area Office and Facility Responsibilities

- Review Meaningful Use presentations to gain an overview of the ONC and CMS requirements

- Review the ONC and CMS rules to understand the details of the requirements

- Ensure that all facilities have full implementations of RPMS EHR on all inpatient units and outpatient clinics

- Ensure that each facility has appropriate support for RPMS and EHR

- Designate a Meaningful Use Coordinator

- Ensure that all relevant staff members have received training on the appropriate methods for using and documenting in the EHR

Area and Facility Responsibilities (Continued)

- Work with the IPC and Meaningful Use Team to change business processes as needed to achieve meaningful use. Examples include:
    - Ensure orders are directly entered into EHR by providers
    - Ensure patients 13 and older are screened for smoking status
- Conduct interoperability tests.
- Determine incentives eligibility and apply for incentives.
- Talk to each state's health information organization to determine requirements for health information exchange. Notify OIT of each state's requirements.
    - Patient summary record, immunization data, lab results, and syndromic surveillance data

Area and Facility Responsibilities (Continued)

- For Medicaid incentives, talk to each state's Medicaid program to determine if additional requirements are needed to achieve meaningful use.

  - States have the option of adding more requirements. Please notify OIT if your state has additional requirements.

- Use the tools that will be added to RPMS for reporting of health IT functionality and clinical quality measures and report as required to CMS and/or the state.

Bottom Line

- Achieving meaningful use does not simply mean installing a certified EHR. Rather, it is just the beginning.

- A lot of work is required by the IHS OIT, the 12 Area Offices, and the hospitals and providers.

- The requirements for achieving meaningful use are not final yet and are subject to change. However, we cannot wait until they are released. Work must start now.

Contact Information

- **IHS Meaningful Use Web site:**

  http://www.ihs.gov/recovery/index.cfm?module=dsp_arra_meaningful_use

- **Sign up for the Meaningful Use listserv (see instructions at the top of the Meaningful Use Web site).**

- **IHS Meaningful Use Contacts:**

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